

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1803	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/05/2011
NAME OF PROVIDER OR SUPPLIER WYNDRIDGE HEALTH AND REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 456 WAYNE AVENUE CROSSVILLE, TN 38555		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 832	<p>1200-8-6-.08(2) Building Standards</p> <p>(2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured.</p> <p>This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to comply with the Tennessee Department of Health Building Standards.</p> <p>The findings include:</p> <p>Observation of the front lobby handicapped bathrooms on 7/5/11 at 8:55 AM, revealed no strobe lights installed in the bathrooms.</p> <p>This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 7/5/11.</p>	N 832	<p>The sprinkler and alarm company, Simplex Grinnell, was contacted to install new strobe type fire alarm lights in lobby bathrooms. This will be monitored by the Director of Plant Operations.</p>	07/21/2011	

Division of Health Care Facilities

[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

[Signature]
Administrator

(X6) DATE

[Signature]
7-20-2011

STATE FORM

6899

IVR421

If continuation sheet 1 of 1

JUL 21 2011